

Title 210 - NEBRASKA DEPARTMENT OF INSURANCE

CHAPTER 46 - LONG-TERM CARE INSURANCE

001. Purpose. The purpose of this regulation is to implement the Long-Term Care Insurance Act, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

002. Authority. This Rule is promulgated under the authority vested in the Director under Neb.Rev.Stat. §44-101.01, §44-404, §44-511, §44-4512, §44-4514, and §44-4518.

003. Applicability and Scope. Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies and certificates, including qualified long-term care insurance contracts, and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, prepaid health plans, health maintenance organizations and all similar organizations. Certain provisions of this regulation apply only to qualified long-term care insurance contracts as noted.

004. Definitions.

004.01 For the purpose of this regulation, the terms "long-term care insurance", "group long-term care insurance", "director", "applicant", "policy" and "certificate" shall have the meanings set forth in the Long-Term Care Insurance Act. The term "qualified long-term care insurance," means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

004.02 Under section 7702B (c)(2)(B) of Internal Revenue Code of 1986, as amended, "activities of daily living" means:

004.02(A) Bathing;

004.02(B) Continence;

004.02(C) Dressing;

004.02(D) Eating;

004.02(E) Toileting; and

004.02(F) Transferring.

004.03 A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual described in subsection 025.01(B)(1) of this regulation takes into account at least five (5) activities of daily living.

005. Policy Definitions and Terms. No long-term care insurance policy or certificate delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy or certificate, and the definitions satisfy the following requirements:

005.01 Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

005.02 "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the home.

005.03 "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

005.04 "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

005.05 "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to a person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

005.06 "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

005.07 "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

005.08 "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

005.09 "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

005.10 "Home health care services" means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

005.11 "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance For the Aged Act," as then constituted and any later amendments or substitutes thereof" or words of similar import.

005.12 "Mental or Nervous Disorder" shall not be defined to include more than

neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

005.13 "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

005.14 "Residential care facility" means any institution, facility, place or building in which there are provided for a period exceeding twenty-four consecutive hours accommodation, board, and care, such as personal assistance in feeding, dressing, and other essential daily living activities, to four or more non-related individuals who by reason of illness, disease, injury, deformity, disability, or physical or mental infirmity are unable to sufficiently or properly care for themselves or manage their own affairs but do not require the daily services of a licensed registered nurse or licensed practical nurse.

005.15 "Skilled nursing care", "intermediate care", "residential care", "personal care", "home health care", and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

005.16 "Skilled nursing facility", "intermediate care facility", "assisted-living facility" shall not be defined more restrictively than the definitions as set forth in Neb.Rev.Stat. §71-401 et seq.

005.17 "Custodial care facility" shall not be defined more restrictively than the definitions for "residential care facility" or "assisted-living facility" as set forth in subsection 005.14 and 005.21 of this regulation.

005.18 "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

005.19 "Transferring" means moving into or out of a bed, chair or wheelchair."

005.20 All providers of services, including but not limited to, "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," "home care agency," "residential care facility," and "assisted-living facility" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

005.21 Assisted Living Facility

005.21(A) Assisted-living facility means a facility where shelter, food, and care are provided for remuneration for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who require or request such services due to age, illness, or physical disability as provided in Neb.Rev.Stat. §71-406.

005.21(B) Assisted-living facility does not include a home, apartment, or facility where (a) casual care is provided at irregular intervals or (b) a competent person residing in such home, apartment, or facility provides for or contracts for his or her own personal or professional services if no more than twenty-five percent of persons residing in such home, apartment, or facility receive such services as provided in Neb.Rev.Stat. §71-406.

006. Policy Practices and Provisions.

006.01 Renewability. The terms "guaranteed renewable" and "non-cancellable" shall not be used in any individual long-term care insurance policy, without further explanatory language in accordance with the disclosure requirements of section 009 of this regulation.

006.01(A) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "non-cancellable."

006.01(B) The term "guaranteed renewable" may be used only

when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

006.01(C) The term "non-cancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

006.01(D) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

006.02 Limitations and Exclusions. A policy or certificate may not be delivered or issued for delivery in this state as long-term care insurance if the policy or certificate limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

006.02(A) Pre-existing conditions or diseases;

006.02(B) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

006.02(C) Alcoholism and drug addiction;

006.02(D) Illness, treatment or medical condition arising out of:

006.02(D)(1) War or act of war (whether declared or undeclared);

006.02(D)(2) Participation in a felony, riot or insurrection;

006.02(D)(3) Service in the armed forces or units auxiliary thereto;

006.02(D)(4) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

006.02(D)(5) Aviation (this exclusion applies only to non-fare paying passengers).

006.02(E) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

006.02(F) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

006.02(G) This subsection 006.02 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

006.03 Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

006.04 Continuation or Conversion.

006.04(A) Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

006.04(B) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation of benefits which

are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

006.04(C) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

006.04(D) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

006.04(E) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

006.04(F) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion

is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

006.04(G) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

006.04(G)(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

006.04(G)(2) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

006.04(G)(2)(i) Providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and

006.04(G)(2)(ii) The premium for which is calculated in a manner consistent with the requirements of subsection 006.04(F).

006.04(H) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

006.04(I) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

006.04(J) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

006.04(K) For the purposes of this section: a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

006.05 Discontinuance and Replacement

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

006.05(A) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

006.05(B) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

006.05(C) The premium~~s~~ charged to an insured for long-term care insurance shall not increase due to either: (1) the increasing age of the insured at ages beyond sixty-five (65); or (2) the duration the insured has been covered under the policy.

006.05(D) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 023, the portion of the premium attributable to the coverage shall be added to and considered part of the initial annual premium.

006.05(E) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under section 023, the initial annual premium shall be based on the reduced benefits.

006.06 Electronic Enrollment for Group Policies

006.06(A) In the case of a group defined in Neb.Rev.Stat. §44-4508 (1), any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

006.06(A)(1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

006.06(A)(2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

006.06(A)(3) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information" is maintained.

006.06B The insurer shall make available, upon request of the Director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

007. Unintentional Lapse

007.01 Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

007.01(A) Notice before lapse or termination. No individual long-term care policy or

certificate shall be issued until the insurer has received from the applicant either a

written designation of at least one person, in addition to the applicant, who is to receive

notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability

on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no

less often than once every two (2) years.

007.01(B) When the policyholder or certificateholder pays premium for a long-term

care insurance policy or certificate through a payroll or pension deduction plan, the

requirements contained in subsection 007.01(A) need not be met until sixty (60) days

after the policyholder or certificate holder is no longer on such a payment plan. The

application or enrollment form for such policies or certificates shall clearly indicate the

payment plan selected by the applicant.

007.01(C) Lapse or termination for nonpayment of premium. No individual long-term

care policy or certificate shall lapse or be terminated for nonpayment of premium unless

the insurer, at least thirty (30) days before the effective date of the lapse or termination,

has given notice to the insured and to those persons

designated pursuant to subsection

007.01(A), at the address provided by the insured for purposes of receiving notice of

lapse or termination. Notice shall be given by first class United States mail, postage

prepaid; and notice may not be given until thirty (30) days after a premium is due and

unpaid. Notice shall be deemed to have been given as of five (5) days after the date of

mailing.

007.02 Reinstatement. In addition to the requirements in subsection 007.01, a long-term care

insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

008. Required Disclosure Provisions.

008.01 Renewability. Individual long-term care insurance policies shall contain a renewal provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

008.02 Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at

reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

008.03 Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

008.04 Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "Pre-existing Condition Limitations."

008.05 Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Neb.Rev.Stat. §44-4513 (7) shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

008.06 Disclosure of Tax Consequences. With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

008.07 Delivery Receipt. When the policy is delivered by an agent, a receipt of delivery of the policy, shall be signed by the agent and applicant, at the time of delivery of the policy, if hand delivered, a copy of which shall be retained by the applicant.

008.08 Refund. If a policyholder returns a policy, as provided by Neb.Rev.Stat. §44-4515, the insurer or organization issuing the long-term care insurance policy shall promptly refund the premium directly to the policyholder.

008.09 Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

008.10 A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in section 026.05, that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

008.11 A non-qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in section 026.05, that the policy is not intended to be a qualified long-term care insurance contract.

009. Prohibition Against Post-Claims Underwriting.

009.01 All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

009.02

009.02(A) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

009.02(B) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

009.03 Except for policies or certificates which are guaranteed issue:

009.03(A) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

009.03(B) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

009.03(C) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

009.03(C)(1) A report of a physical examination;

009.03(C)(2) An assessment of functional capacity;

009.03(C)(3) An attending physician's statement; or

009.03(C)(4) Copies of medical records.

009.04 A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

009.05 Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Director in the format as

prescribed by the Director, and/or the National Association of Insurance Commissioners in Appendix A.

0010. Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies.

0010.01 A long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits:

0010.01(A) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

0010.01(B) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home, or community or institutional setting before home health care services are covered;

0010.01(C) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

0010.01(D) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

0010.01(E) By requiring that the insured/claimant have an acute condition before home health care services are covered;

0010.01(F) By limiting benefits to services provided by Medicare-certified agencies or providers;

0010.01(G) By excluding coverage for personal care services provided by a home health aide;

0010.01(H) By requiring that the provisions of home health care services be at a level of certification of licensure greater than that required by the eligible service;

0010.01(I) By excluding coverage for adult day care services.

0010.02 A long-term care insurance policy or certificate, if it provides for

home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

011. Requirement to Offer Inflation Protection.

011.01 No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

011.01(A) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

011.01(B) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

011.01(C) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

011.02 Where the policy is issued to a group, the required offer in subsection 010.01 shall be made to the group policyholder; except, if the policy is issued to a group defined in Neb.Rev.Stat. §44-4508(4) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

011.03 The offer in subsection 011.01 shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

011.04 Insurers shall include the following information in or with the outline of coverage:

011.04(A) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

011.04(B) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

011.04(C) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purpose of this disclosure.

011.05 Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

011.06 An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

011.07 Inflation protection.

011.07(A) Inflation protection as provided in subsection 011.01(A) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

011.07(B) The rejection shall be considered a part of the application and shall state: I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

012. Requirements for Application Forms and Replacement Coverage.

012.01 Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a

long-term care policy or certificate is intended to replace any other sickness and accident or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by Neb.Rev.Stat. §44-4508(1), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

012.01(A) Do you have another long-term care insurance policy or certificate in force (including a health care service contract, and/or a health maintenance organization contract)?

012.01(B) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

012.01(B)(i) If so, with which company?

012.01(B)(ii) If that policy lapsed, when did it lapse?

012.01(C) Are you covered by Medicaid?

012.01(D) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

012.02 Agents shall list any other health insurance policies they have sold to the applicant.

012.02(A) List policies sold which are still in force.

012.02(B) List policies sold in the past five (5) years which are no longer in force.

012.03 Solicitations Other than Direct Response. Upon determining that a sale will involve replacement or addition to existing coverage, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of or addition to existing sickness and accident or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF OR ADDITION TO INDIVIDUAL SICKNESS AND ACCIDENT OR
LONG-TERM CARE INSURANCE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate or add to existing sickness and accident or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

[For replacements only] You should review this new coverage carefully, comparing it with all sickness and accident or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has

taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted)

under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate or add to your present policy, and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)

[Type Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Applicant's
Signature)

012.04 Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of sickness and accident or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF OR ADDITION TO SICKNESS AND ACCIDENT OR**

LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate or add to existing sickness and accident or long-term care insurance and replace or add to it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

[For replacements only] You should review this new coverage carefully, comparing it with all sickness and accident or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to

[company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

012.05 Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

012.06 Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 210, Nebraska Administrative Code, Chapter 19, Replacement of Life Insurance and Annuities. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

013. Reporting Requirements.

013.01 Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

013.02 Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by Subsection 013.01 above.

013.03 Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

013.04 Every insurer shall report annually by June 30 the number of lapsed

policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

013.05 Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

013.06 Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

013.07 For purposes of this section:

013.07(A) "Policy" means only long-term care insurance.

013.07(B) Subject to subsection 013.07(3), "claim" means a request for payment of benefits under an enforce policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

013.07(C) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

013.07(D) "Report" means on a statewide basis.

013.08 Reports required under this section shall be filed with the Director.

014. Licensing. No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses.

015. Discretionary Powers of Director. The Director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

015.01 The modification or suspension would be in the best interest of the insureds; and

015.02 The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

015.03

015.03(A) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

015.03(B) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

015.03(C) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

016. Reserve Standards.

016.01 When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Neb.Rev.Stat. §44-404. Claim reserves must also be established in the case when such policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

016.01(A) Definition of insured events;

016.01(B) Covered long-term care facilities;

016.01(C) Existence of home convalescence care coverage;

016.01(D) Definition of facilities;

016.01(E) Existence or absence of barriers to eligibility;

016.01(F) Premium waiver provision;

016.01(G) Renewability;

016.01(H) Ability to raise premiums;

016.01(I) Marketing method;

016.01(J) Underwriting procedures;

01.01(K) Claims adjustment procedures;

016.01(L) Waiting period;

016.01(M) Maximum benefit;

016.01(N) Availability of eligible facilities;

016.01(O) Margins in claim costs;

016.01(P) Optional nature of benefit;

016.01(Q) Delay in eligibility for benefit;

016.01(R) Inflation protection provisions; and

016.01(S) Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

016.02 When long-term care benefits are provided other than as in subsection 016.01 above, reserves shall be determined in accordance with the minimum standards for sickness and accident insurance policies.

017. Loss Ratio.

017.01 Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

017.01(A) Statistical credibility of incurred claims experience and earned premiums;

017.01(B) The period for which rates are computed to provide coverage;

017.01(C) Experienced and projected trends;

017.01(D) Concentration of experience within early policy duration;

017.01(E) Expected claim fluctuation;

017.01(F) Experience refunds, adjustments or dividends;

017.01(G) Renewability features;

017.01(H) All appropriate expense factors;

017.01(I) Interest;

017.1(J) Experimental nature of the coverage;

017.1(K) Policy reserves;

017.1(L) Mix of business by risk classification; and

017.1(M) Product features such as long elimination periods, high deductibles and high maximum limits.

017.02 Subsection 017.01 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

017.02(A) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate

for cash value accumulations without long-term care set forth in the policy;

017.02(B) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Neb.Rev.Stat. §44-407.01;

017.02(C) The policy meets the disclosure requirements of Neb.Rev.Stat. §44-4516(4), (5), and §44-4517 of the Long-Term Care Insurance Act;

017.02(D) Any policy illustration that meets the applicable requirements of the Life Insurance Illustrations Regulation; and

017.02(E) An actuarial memorandum is filed with the insurance department that includes:

017.02(E)(1) A description of the basis on which the long-term care rates were determined;

017.02(E)(2) A description of the basis for the reserves;

017.02(E)(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

017.02(E)(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

017.02(E)(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

017.02(E)(6) The estimated average annual premium per policy and the average issue age;

017.02(E)(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

017.02(E)(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claims status.

018. Filing Requirement. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Neb.Rev.Stat. §44-4511, it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

019. Filing Requirements for Advertising.

019.01 Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Director of this state for review or approval by the Director to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

019.02 The Director may exempt from these requirements any advertising form or material when, in the Director's opinion, this requirement may not be reasonably applied.

020. Standards for Marketing.

020.01 Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

020.01(A) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

020.01(B) Establish marketing procedures to assure excessive insurance is not sold or issued.

020.01(C) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

020.01(D) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has sickness and accident or long-term care insurance and the types and amounts of any such insurance except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

020.01(E) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subsection 020.01.

020.01(F) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Director, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that such a program is available and the name, address and telephone number of the program.

020.01(G) For long term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to section 006.01(C) of this regulation.

020.02 In addition to the practices prohibited in Neb.Rev.Stat. §44-1522 through §1544, the following acts and practices are prohibited:

020.02(A) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

020.02(B) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

020.02(C) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

020.02(D) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

020.03

020.03(A) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as referenced in Neb.Rev.Stat. §44-4508, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. This paragraph shall not apply to qualified long-term care insurance contracts.

020.03(B) The insurer shall file with the insurance department the following material:

020.03(B)(1) The policy and certificate,

020.03(B)(2) A corresponding outline of coverage, and

020.03(B)(3) All advertisements requested by the insurance department.

020.03(C) The association shall disclose in any long-term care insurance solicitation:

020.03(C)(1) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

020.03(C)(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

020.03(D) If the association and the insurer have interlocking directorates or

trustee arrangements, the association shall disclose that fact to its members.

020.03(E) The board of directors of associations selling or endorsing long-

term care insurance policies or certificates shall review and approve the insurance

policies as well as the compensation arrangements made with the insurer.

020.03(F) The association shall also:

020.03(F)(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

020.03(F)(2) Actively monitor the marketing efforts of the insurer and its agents; and

020.03(F)(3) Review and approve all marketing materials

or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

020.03(F)(4) Subsections 020.03(F)(1) through 020.03(F)(3) shall not apply to qualified long-term care insurance contracts.

020.03(G) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

020.03(H) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

020.03(I) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of Neb.Rev.Stat. §44-1521 through §44-1535.

021. Suitability.

21.01 This section shall not apply to life insurance policies that accelerate benefits for long-

term care.

21.02 Every insurer, health care service plan or other entity marketing long-term care

insurance (the "issuer") shall:

021.02(A) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

021.02(B) Train its agents in the use of its suitability standards; and

021.02(C) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

021.03

021.03(A) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop

procedures that take the following into consideration:

021.03(A)(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

021.03(A)(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

021.03(A)(3) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

021.03(B) The issuer, and where an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subsection 021.03 above. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet." The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Director.

021.03(C) A completed personal worksheet shall be returned to the issuer, and a copy shall be provided to the applicant, prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

021.03(D) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in Appendix B is prohibited.

021.04 The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

021.05 Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

021.06 At the same time as the personal worksheet is provided to the

applicant, the disclosure form entitled "Things You should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than twelve (12) point type.

021.07 If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or record of the alternative method of verification shall be made part of the applicant's file.

021.08 The issuer shall report annually to the Director the total number of applications received from the residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

022. Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or

Certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

023. Nonforfeiture Benefit Requirement

023.01 This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

023.02 To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Neb.Rev.Stat. §44-4517.02:

023.02(A) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 023.05; and

023.02(B) The offer shall be in writing if the nonforfeiture benefit is

not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

023.03 If the offer required under Neb.Rev.Stat. §44-4517.02 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

023.04

023.04(A) After rejection of the offer required under Neb.Rev.Stat. §44-4517.02, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

023.04(B) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

023.04(C) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Percent Increase Over

Issue Age Initial Premium

29 and under 200%

1. 190%

1. 170%

1. 150%

1. 130%
1. 110%
1. 90%
1. 70%
2. 66%
3. 62%
4. 58%
5. 54%
6. 50%
7. 48%
8. 46%
9. 44%
10. 42%
11. 40%
12. 38%
13. 36%
14. 34%
15. 32%
16. 30%
17. 28%
18. 26%
19. 24%
20. 22%
21. 20%
22. 19%
23. 18%
24. 17%
25. 16%
26. 15%
27. 14%
28. 13%
29. 12%
30. 11%

90 and over 10%

023.04(D) On or before the effective date of a substantial premium increase as defined in subsection 023.04(C) above, the insurer shall:

023.04(D)(1) Offer to reduce policy benefits provided by the current coverage without the requirement of

additional underwriting so that required premium payments are not increased;

023.04(D)(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection 023.05. This option may be elected at any time during the 120-day period referenced in subsection 023.04(C); and

023.04(D)(3) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection 023.04(C) shall be deemed to be the election of the offer to convert in subsection 023.04(D)(2) above.

023.05 Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection.

023.05(A) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

023.05(B) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection 023.05(C).

023.05(C) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection 023.06.

023.05(D)

023.05(D)(1) The nonforfeiture benefit and the

contingent benefit upon lapse shall begin not later than the end of the third year following the policy or certificate issue date.

023.05(D)(2) Notwithstanding subsection 023.05(D)(1), except for a policy or certificate with a contingent benefit upon lapse or a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

023.05(D)(2)(i) The end of the tenth year following the policy or certificate issue date;
or

023.05(D)(2)(ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

023.05(E) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

023.06 All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

023.07 There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

023.08 The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

023.08(A) Except as provided in subsection 023.08(B), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

023.08(B) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in Neb.Rev.Stat. §44-4508(1), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

023.09 Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of section 017 treating the policy as a whole.

023.10 To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection 023.04(C), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

023.11 A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall meet the following requirements:

023.11(A) The nonforfeiture provision shall be appropriately captioned;

023.11(B) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts filed with the Director for the same contract form; and

023.11(C) The nonforfeiture provisions shall provide at least one of the following:

023.11(C)(1) Reduced paid-up insurance;

023.11(C)(2) Extended term insurance;

023.11(C)(3) Shortened benefit period; or

023.11(C)(4) Other similar offerings approved by the Director.

Section 024. Standards for Benefit Triggers

024.01 A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

024.02 Activities of daily living

024.02(A) Activities of daily living shall include at least the following as defined in section 005 and in the policy:

024.02(A)(1) Bathing;

024.02(A)(2) Continence;

024.02(A)(3) Dressing;

024.02(A)(4) Eating;

024.02(A)(5) Toileting; and

024.02(A)(6) Transferring.

024.02(B) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subsection 024.02 (A) as long as they are defined in the policy.

024.03 An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 024.01 and 024.02.

024.04 For purposes of this section the determination of a deficiency shall not be more restrictive than:

024.04(A) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

024.04(B) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

024.05 Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

024.06 Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

024.07 The requirements set forth in this section shall become effective twelve (12) months after adoption of this provisions and shall apply as follows:

024.07(A) Except as provided in subsection 024.07(B), the provisions of this

section apply to a long-term care policy issued in this state on or after the effective date

of the amended regulation.

024.07(B) For certificates issued on or after the effective date of this section, under

a group long-term care insurance policy as defined in Neb.Rev.Stat. §44-4508(1) that

was in force at the time this amended regulation became effective, the provisions of this

section shall not apply.

Section 025. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts.

025.01 For purposes of this section the following definitions apply:

025.01(A) "Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code as of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

025.01(B)

025.01(B)(1) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a "licensed health care practitioner" as:

025.01(B)(1)(i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily

living for a period of at least ninety (90) days due to a loss of functional capacity; or

025.01(B)(1)(ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

025.01(B)(2) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

025.01(C) "Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

025.01(D) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

025.02 A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

025.03 A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment.

025.04 Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 025.03 shall be performed by the following licensed or certified professionals: physicians; registered professional nurses; licensed social workers; or other individuals who meet requirements prescribed by the Secretary of the Treasury.

025.05 Certifications required pursuant to subsection 025.03 may be performed by a licensed health care professional at the direction of the carrier

as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be recinded and additional certifications may not be performed until after the expiration of the ninety (90) day period.

025.06 Qualified long-term care contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

026. Standard Format Outline of Coverage. This section of the regulation implements, interprets and makes specific, the provisions of Neb.Rev.Stat. §44-4512 and §44-4516 in prescribing a standard format and the content of an outline of coverage.

026.01 The outline of coverage shall be a free-standing document, using no smaller than ten point type.

026.02 The outline of coverage shall contain no material of an advertising nature.

026.03 Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

026.04 Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

026.05 Format for outline of coverage:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution

statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

-

OR

Federal Tax Implication of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally a tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE
MAY BE CONTINUED IN FORCE OR DISCONTINUED

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

- a. [Describe waiver of premium provisions or state that there are not such provisions;]

(d) [State whether or not the company has a right to change premium, and if such right exists, describe clearly and concisely each circumstance under which premium may change.]

5. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return – "free look" provision of the policy".]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

6. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

7. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

8. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

9. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (7) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-

TERM CARE NEEDS.

10. RELATIONSHIP OF COST OF CARE AND BENEFITS.

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

- (a) That the benefit level will not increase over time;
- (b) Any automatic benefit adjustment provisions;
- (c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
- (d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
- (e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

11. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

12. PREMIUM.

- [(a) State the total annual premium for the policy;
- (b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

13. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

027 Requirement to Deliver Shopper's Guide.

027.01 A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Director, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

027.01(A) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

027.01(B) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

027.02 Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish a policy summary required under Neb.Rev.Stat. §44-4512 through §44-4517.

028. Penalties. In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

029. Severability. If any section or portion of a section of this Regulation, or the applicability thereof to any person or circumstance, is held invalid by a court, the remainder of this regulation, or the applicability of such provision to other persons, shall not be affected thereby.

030. Effective Date. The operative date of this regulation is October 1, 2000.

This regulation shall apply to all long-term care insurance policies and certificates delivered or issued for delivery in this state by an insurer on or after October 1, 2001.

APPENDIX A
RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF _____
FOR THE REPORTING YEAR 20[]

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claims/s Submitted	Date of Rescission

Detailed reason for rescission:

Signature

Name and Title (please type)

Date

APPENDIX B

LONG TERM CARE INSURANCE

PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must **ask** you to fill out this worksheet to help you and the company decide if you should buy this policy.

Premium

The premium for the coverage you are thinking about buying will be [\$ per month, or \$ per year,] [a one-time single premium of \$.]

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums in the future.] The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The last rate increase for this policy in this state was in [year], when premiums went up an average of %]. [The company has not raised its rates for this policy.]

Drafting Note: The issuer shall use the bracketed sentence or sentences applicable to the product offered. If a company includes a statement regarding not having raised rates, it must disclose the company's rate increases under prior policies providing essentially similar coverage. The issuer may include rate information for up to two policy forms if the issuer has not changed rates on either policy form or for prior policies providing essentially similar coverage.

- [Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer shall use the bracketed sentence unless the policy is fully paid up or is a noncancellable policy.

How will you pay each year's premium?

- From my Income From my Savings \ Investments My Family will pay

Income

What is your annual income? (check one)

Under \$10,000 \$[10-20,000] \$[20-30,000] [\$30-50,000] Over \$50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

No Change Increase Decrease

If you will be paying premiums from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Savings and Investments

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

Under \$20,000 \$20,00-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (Check one)

Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

The answer to the questions above describe my financial situation.	I choose not to complete this Information
--	---

Signed: _____

(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: _____

(Applicant) (Date)

Agent's Printed Name:]

[**Note:** In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

-

Signed: _____

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading

"Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care • A long-term care insurance policy may pay most of the costs for

Insurance your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare • Medicare does **not** pay for most long-term care.

Medicaid • Medicaid will generally pay for long-term care if you have very

little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial

resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's • Make sure the insurance company or agent gives you a copy of a

Guide book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling • Free counseling and additional information about long-term care

insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

-

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which

asked questions about your finances and your reasons for buying long-term care insurance. For

your protection, state law requires us to consider this information when we review your

application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We

suggest that you review the information provided with your application, including the booklet "Shoppers Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

- **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

- **No.** I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

Claims Denial Reporting Form

Long-Term Care Insurance

For the State of _____

For the Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC #: _____

Contact Person: _____ Phone #: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

.

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example – home health care claim filed under a nursing home only policy.
3. Example – a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples – a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.